RESPONSE BY APPLICANTS

TO

FEDERAL TRADE COMMISSION STAFF SUBMISSION

ON JANUARY 13, 2017

AND

ANTHEM HEALTH PLANS SUBMISSION

ON JULY 17, 2017

TO VIRGINIA DEPARTMENT OF HEALTH REGARDING

COOPERATIVE AGREEMENT APPLICATION

Pursuant to Virginia Code § 15.2-5384.1
and the regulations promulgated thereunder at 12VAC5-221-10 *et seq.*

Submitted by: Mountain States Health Alliance
Wellmont Health System

Date: September 1, 2017

On January 13, 2017, FTC staff submitted supplemental comments to the Application by Mountain States Health Alliance and Wellmont Health System for a Cooperative Agreement.[1] On July 17, 2017, Anthem also submitted supplemental comments.[2] The Parties submit this very short response to them, to address just a few fundamental points. A longer response is unnecessary. Since (and before) last January's FTC staff submission, the Parties have submitted volumes of additional information to the Department in the form of documents, very detailed written answers to the Department's many important questions, and discussions in face to face meetings with Virginia officials, including on issues raised by staff.

In the January 13 submission, staff double down on their flawed themes. In their prior submission of September 30, 2016, staff revealed their bias in favor of an antitrust law regime and against the Cooperative Agreement Law and the sovereign Virginia policy that underlies it. That submission also was fundamentally flawed in its mistaken equivalency of antitrust law analysis (to determine if a merger is anticompetitive and should be blocked) with Cooperative Agreement Law analysis (to assess whether even an anticompetitive merger should proceed under a regulatory program and active supervision). It also highlighted staff's blind eye to the Cooperative Agreement Law's unanimous enactment as a potential remedy for Southwest Virginia's pervasively poor economic and health conditions, which staff ignore.

Staff do not dispute and largely ignore the detailed 168-page findings and conclusions contained in the December 22, 2016 Review of the Application conducted by the Southwest Virginia Health Authority ("Authority") recommending approval of the Application.[3] The Authority Review was conducted over ten months by a thirty-member board which included a wide range of regional health leaders, local health care providers, local representatives, and members of the Virginia General Assembly, individuals with first-hand knowledge of the significant health care needs in the area and the economic challenges. The Authority also retained three "well-credentialed" consultants with significant expertise in health care.

The Authority concluded based on this extensive analysis that the *status quo* was not working and, after evaluating each of the specific benefits and disadvantages set forth in the statute, concluded that the benefits outweighed the disadvantages. These important benefits included, according to the Authority, the commitments on the rural hospitals and the increased mental health and substance abuse services to address the opioid epidemic in the region. In the Application and subsequent submissions, the Parties have presented voluminous, and unrefuted,

[1] Federal Trade Commission Staff Supplemental Submission to the Virginia Department of Health Regarding the Cooperative Agreement Application of Mountain States Health Alliance and Wellmont Health System (January 13, 2017) (hereinafter "January 2017 submission" or "supp. comments").

[2] "Supplemental Submission of Anthem Health Plans of Virginia, Inc. [to] the Virginia Department of Health" (July 17, 2017) ("Anthem July submission").

[3] A Review of the Commonwealth of Virginia Application for a Letter Authorizing a Cooperative Agreement Filed by Mountain States Health Alliance and Wellmont Health System, The Southwest Virginia Health Authority, December 22, 2016 ("Authority Review").

information on the poor state of health of the people in Southwest Virginia, and its significant implications for quality of life along with medical and productivity costs.

Staff's other arguments have no merit.

1. ***Staff misconstrue the burden of proof***. Staff's evidentiary arguments fail to follow the Cooperative Agreement Act's clear directive to weigh benefits and disadvantages *as a whole* in determining whether the cooperative agreement should be authorized. As long as the likely advantages *as a whole* outweigh the disadvantages *by any amount*, then the public would benefit from the proposed agreement and the Act requires approval of the Application. The Cooperative Agreement Act's clear directive is that approval does not depend on any particular element; rather the evidentiary standard applies to the weighing of benefits and disadvantages as a whole.

2. ***Staff's reliance on their cited economic literature is misplaced.*** Staff complain that the Parties did not appropriately heed their prior submission's "detailed references to sources, data, and analyses" supporting their conclusions. (supp. comments at 2) The avalanche of studies and references on which staff claim support, however, catalogues only mergers that were done outside of a regulatory framework like a cooperative agreement and that were not subject to active state supervision. Staff's failure to acknowledge the deficiency of empirical evidence in support of their institutional opposition to cooperative agreements is glaring. The Parties, on the other hand, provided compelling, unrebutted evidence that other COPAs led to lower costs, lower pricing and nationally recognized higher quality.

3. ***Staff's supposed "alternative arrangements" to the merger are illusory.*** Staff mistakenly charge that the Parties "failed to provide any analysis of available alternative arrangements" (one of the statutory factors out of many). (supp. comments at 2) The Parties' response to staff's first set of comments[4] points out that Wellmont received eight proposals and undertook a very deliberate process of evaluating the alternatives, all of which would have replaced Wellmont with an out-of-market organization unregulated by enforceable commitments on community benefits and rate caps. Both Parties provided information that potential suitors of each system claimed they could "improve" pricing and in some cases "centralize" corporate operations outside the Parties' respective service areas. The Parties each reached the conclusion that pricing would increase and more jobs would be lost in the region by such "alternative arrangements." Staff do not dispute that they "provide[d] no detail" about any alternative arrangement that would actually generate similar benefits as those proposed by the Parties. (supp. comments at 2)

4. ***Staff cling to a misguided reliance on antitrust law merger analysis.*** Staff claims that the FTC Merger Guidelines framework is "remarkably similar" to the "Commonwealth's policy laid out in the Virginia Cooperative Agreement Act." (supp. comments at 4) This is irreconcilable with the facts, as explained in the Parties' October 2016 Submission. In

[4] "Response by Applicants to Federal Trade Commission Staff Submission of September 30, 2016 and Supporting Memorandum to the Southwest Virginia Health Authority and Virginia Department of Health Regarding Cooperative Agreement Application" (October 14, 2016) ("Parties' October 2016 Submission"), at 24-25. The Parties also responded to similar claims by Anthem. *See* "Response by Applicants to Submissions of Anthem, VAHP and AHIP to the Southwest Virginia Health Authority and Virginia Department of Health Regarding Cooperative Agreement Application" (October 21, 2016), at 5-7.

fundamental ways, federal antitrust policy and Virginia policy articulated through the Cooperative Agreement Law sharply diverge. Virginia policy promotes qualified hospital mergers even if they reduce competition. Federal antitrust policy stops anticompetitive mergers in their tracks. Virginia policy evaluates a hospital merger's benefits for value beyond their effects on competition. Federal antitrust policy accords no weight to any benefit that is not substantiated for how it will "enhance the merged firm's ability and incentive to compete."[5]

5. ***Staff incorrectly charge that the Parties ignored statutory elements.*** Staff contend the Parties are deficient in not providing "a full analysis of the competitive harm" from the merger, because otherwise "it is not possible to conduct the balancing test required by the Virginia statute." (supp. comments at 4) This also is untrue. The Parties supplied volumes of market information to the Commissioner, as the regulations require, enabling the Commissioner to assess the merger's competitive implications absent effective regulation and active supervision. These materials include a detailed description of the Parties' current and proposed primary and secondary service areas, identification of all services, products and locations to be affected by the Cooperative Agreement, market share estimates, service location maps, and a statement about the merger will reduce. Staff divorced their structural analysis and prediction of gigantic price increases from the reality that the merger, if approved, will be subject to regulation, ironclad commitments including a rate cap, and active supervision.

6. ***Staff's criticisms of the Parties' commitments are wrong.*** As noted above, the Parties have submitted a large volume of materials and held in-depth discussions with the Commissioner's team regarding the commitments, both before and after the FTC made this submission. Due to the very large number of commitments that have been submitted and staff's myriad complaints about them, the Parties refer the Commissioner to the submitted record for the showing that staff's arguments have no merit.

Staff never contested volumes of critical facts underlying the Application. See Exhibit A.

Anthem's recent comments are also highly flawed. Many, as Anthem acknowledges, are repeated from its earlier comments (Anthem July submission at 2); the Parties previously addressed many of them.[6] Anthem recognizes the "unique health care challenges" that exist in Southwest Virginia (Anthem July submission at 1) but offers no solutions. It also does not dispute any of the significant benefits of the Parties' substantial financial and other commitments designed to improve healthcare in the region. Anthem does not challenge the Parties' specific commitments on rural hospitals, but then curiously references a newspaper article about a failing rural hospital in Lee County. (Anthem July submission at 2) Like FTC staff, Anthem identifies no alternative arrangements that would address the region's pressing economic and healthcare problems on a par with the proposed merger and provide the merger's same level of enforceable commitments. Anthem maintains that the Parties could form a regional Accountable Care Community absent a merger (Anthem July submission at 5), but does not claim that this initiative would even remotely approach the same level of benefits provided by the proposed merger.

For the reasons stated above, therefore, the Commissioner should reject the arguments of staff and of Anthem set forth in their respective January 2017 and July 2017 submissions.

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[5] FTC Merger Guidelines at 30.

[6] See note 4, *supra*.

EXHIBIT A

FACTS NOT CONTESTED BY STAFF

Poor Population Health. Staff do not dispute that the region suffers disproportionately from numerous significant health care challenges—obesity, diabetes, low birthweights, tobacco and substance abuse, high rates of opioid addiction and death from addiction, high blood pressure, high cholesterol levels, and physical inactivity. Parties' October 2016 Submission at 23-24.

Reduction in Residencies. Staff do not dispute that due to financial pressures facing the Parties, each system was reducing the number of funded residency programs in the area, which reduces pipeline of future physicians for the region. *Id.* at 32.

Expanded Services; Community Health Initiatives. Staff do not dispute the need for additional important services such as outpatient mental health, residential addiction recovery and expansion of pediatric services, which the Parties are committed to providing. *Id.* At 21-22, 26-27. Nor do staff dispute the need for the following initiatives which the Parties have committed to fund with an investment of not less than $75 million: ensure strong starts for children, help adults live well in the community, promote a drug free community and decrease avoidable hospital admissions and ER use. *Id.* at 21-22, 26-27.

Largely Rural Service Area. Staff do not dispute that virtually all of the residents of the counties served by Ballad in Southwest Virginia live in areas classified as rural. *Id.* at 23.

Parties Facing Financial Pressure. Staff do not dispute that the Parties are facing significant financial pressures, especially for rural hospitals, including disproportionate levels of uncompensated care and Medicaid, fixed cost structures required to keep the rural hospitals open, declining or stagnant populations, which is projected to continue, declining inpatient use rates, and the second lowest Area Wage Index in the United States (making Medicare and Medicaid reimbursement, which represent 70 percent of the payer mix, among the lowest in the nation), and a small and shrinking base of commercial patients with downward pressure on reimbursement. *Id.* at 2, 13, 20.

Low Census and Occupancy. Staff do not dispute that most of the Parties' Virginia rural hospitals currently have an average daily census of thirty patients or less, with licensed bed occupancy at these hospitals ranging from 0.1% to 36.7%. *Id.* at 2.

Rural Hospitals Closing. Staff do not dispute that 78 rural hospitals have closed since 2010, including eight in Tennessee and one in Virginia, and more that 600 could be vulnerable going forward. *Id.* at 2.

Overwhelming Community Support. Staff do not dispute the overwhelming community support for the merger from employers, government officials and residents. *Id.* at 4-6.

Absence of Available Alternatives. Staff do not dispute that they are unable to provide evidence of the availability of any alternative arrangement that would provide the same level of

benefits and enforceable commitments that this merger provides. *Id.* at 24-25.

Benefits of the Mission Health COPA. Staff do not dispute that the Mission Health COPA resulted in substantial benefits, including pricing well within the mainstream of hospital pricing, costs well within the median of a COPA peer group, recognition as one of the highest value hospital systems in the nation and recognition as one of the top hospitals in the country. *Id.* at 37-38.

Factors Ensuring High Quality. Staff do not dispute that several factors will keep quality at high levels, including the importance of national quality measures, payment incentives and penalties, reimbursement tied to quality measures, including reimbursement from government payers, and competition from out of area systems. *Id.* at 26.

Benefits of the Common IT Platform. Staff do not dispute the many benefits from the Common Clinical IT Platform. *Id.* at 27-30.

Transparency of Quality Reporting. Staff do not dispute the benefits of greater transparency in quality reporting. *Id.* at 30-32.

Additional Funding for Training and Research. Staff do not dispute the importance of additional funding for academic and research opportunities, including training of health care professionals, which the Parties have committed to fund with $85 million in incremental funds over ten years. *Id.* at 32.